RHINE Chiropractic & Rehabilitation Center
ProAdjuster Clinic
4684 Broadway, Allentown, PA 18104 • (610) 391-0858 • Fax (610) 391-0528

Confidential Patient Health Record

Date:____/_____/________

Personal History

Circle One: Divorced Married Single Separated Widowed Birth Date: ____ /_____/________ Age:______
First:___________________ Middle:__________ Last: ________________________ Gender: Male / Female
Address: ____ Apt # __________
City: ___________________ State: ______ Zip: _________ County: ___________________ Country: ____________
Home Phone: (__________)_____________-______________ Cell Phone: (________)_________-___________
Social Security #: _________-_________-_____________ Fax #: (________)_________-___________
Driver's License #: _____________________ State: _______ Email Address: ______________________________
Spouse's Name: _____________________________________
Ages of Children: ____

Employer
Business Name: ____________________________________ Occupation/Job Title: _________________________
Business Address: ____
Business Phone: (___________)__________-___________ Type of Work:________________________________

How did you hear about us? ____

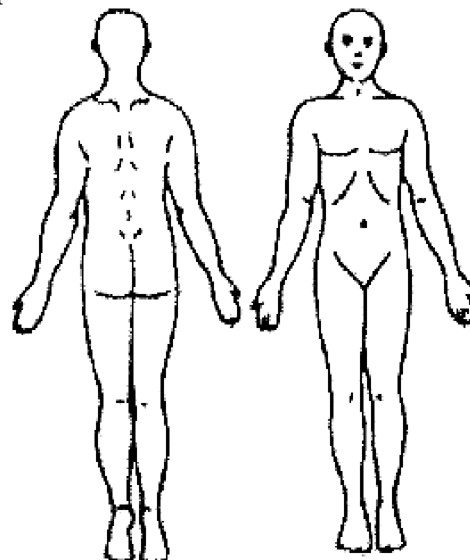
Emergency Contact
Name: ____ Phone Number: (________)________-__________
Address: ____
Relationship:_____________________________________

Who Is Responsible For Your Bill?
☐ Self ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (be specific):_____________________
Personal Health Insurance Carrier: __________________ Health ID Card #: ____________________________
Insured Person's Name: _________________________ Group #: ___________________________________
Insured Person's Date of Birth: _____________________ Primary Care Physician: ______________________
Insured Person's Social Security #: _____-_____-_______ Pharmacy: __________________________________

CURRENT HEALTH CONDITION
Chief complaint (Why you are here today):________________
____
____

Use the letters below to indicate the type and location of your sensations right now:
A= Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT
→ → → → → → →



When did this condition begin? _____/_______/_________
Has it ever occurred before? ☐ Yes ☐ No
When? ____
Is the condition: ☐ Auto Related ☐ Work Related
☐ No Injury ☐ Other

Explain: ____
____
Date of Accident: _______________________________________
Time of Accident: _______________________________________
Complaint/Pain Onset Date: ______________________________
If Work Related:
Have you filed an injury report with your employer? ☐Yes ☐ No
Claim #: ____

Have you seen other doctors for this condition?□ Yes □ No If yes, Who?(Name)______________________________
Location of Office: __________________________________ Type of Treatment:________________________________
Were you satisfied with the results of your treatment? □ Yes □ No Explain:________________________________
Are you currently taking any prescription medications? □ Yes □ No. If yes, please mark or list below (be specific).
□ Allergy Medication □ Anti-Depressants □ Blood Pressure Medication □ Insulin □ Muscle Relaxers
□ Nerve Pills □ Pain Killers □ Other (please be specific): ___________________________________

Do you wear any of the following? □Yes □ No. If yes, please mark: □ Heel Lifts □ Innersoles □ Arch Supports □ Orthotics

Please list any other conditions you feel we should know about – even if unrelated:
____
____
____

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.

REVIEW OF SYSTEMS – Please fill out all of the sections, even if "DENY".

Constitutional: **I… □ Deny Any Constitutional Issue (s)**
□ Chills □ Daytime Somnolence (Drowsiness) □ Fatigue □ Fever □ Night Sweats
□ Weight Gain □ Weight Loss

Eyes/Vision: **I… □ Deny Any Eyes/Vision Issue (s)**
□ Blindness □ Blurred Vision □ Cataracts □ Change in vision □ Double Vision
□ Eye Pain □ Field Cuts (visual field defect) □ Glaucoma □ Itching (around the eyes) □ Photophobia
□ Tearing □ Wears Glasses and/or Contact lenses

Ears, Nose and Throat: **I… □ Deny Any Ears, Nose and Throat Issue (s)**
□ Bleeding □ Dental Implants □ Dentures □ Difficulty Swallowing □ Discharge
□ Dizziness □ Ear Drainage □ Ear Infection(s) □ Ear Pain □ Fainting
□ Headaches □ Head Injury (history of) □ Hearing Loss □ Hoarseness □ Loss of Smell
□ Nasal Congestion □ Nose bleeds (frequent) □ Post Nasal Drip □ Rhinorrhea (Runny nose) □ Sinus Infections
□ Snoring □ Sore Throats (frequent) □ Tinnitus (Ringing in Ears) □ TMJ problems

Respiration: **I… □ Deny Any Respiratory Issue (s)**
□ Asthma □ Cough □ Coughing up blood □ Shortness of Breath □ Sputum Production
□ Wheezing

Cardiovascular: **I… □ Deny Any Cardiovascular Issue (s)**
□ Angina (chest pain or discomfort □ Chest Pain □ Claudication (leg pain or achiness) □ Heart Murmor
□ Heart Problems □ Orthopnea (difficulty breathing while lying down) □Palpitations (irregular or forceful beating of the heart)
□ Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath) □ Shortness of Breath with Exertion or Exercise
□ Swelling of Legs □ Ulcers □ Varicose Veins

Gastrointestinal: **I… □ Deny Any Gastrointestinal Issue (s)**
□ Abdominal Pain □ Belching □ Black, Tarry Stools □ Constipation □ Diarrhea
□ Difficulty Swallowing □ Heartburn □ Hemorrhoids □ Indigestion □ Jaundice (yellowing of the skin)
□ Nausea □ Rectal Bleeding □ Abnormal Stool Caliber (quality) □ Abnormal Stool Color
□ Abnormal Stool Consistency □ Vomiting □ Vomiting Blood

Female: **I… □ Deny Any Female Issue (s)**
□ Birth Control Therapy □ Breast Lumps/Pain □ Burning Urination □ Cramps □ Frequent Urination
□ Hormone Therapy □ Irregular Menstruation □ Urine Retention □ Vaginal Bleeding □ Vaginal Discharge

Male: **I… □ Deny Any Male Issue (s)**
□ Burning Urination □ Erectile Dysfunction □ Frequent Urination □ Hesitancy/Dribbling □ Prostate Problems
□ Urine Retention

Endocrine: I… ☐ Deny Any Endocrine Issue (s)
☐ Cold Intolerance ☐ Diabetes ☐ Excessive Appetite ☐ Excessive Hunger ☐ Excessive Thirst
☐ Frequent Urination ☐ Goiter ☐ Hair Loss ☐ Heat Intolerance ☐ Unusual Hair Growth
☐ Voice Changes

Skin: I… ☐ Deny Any Skin Issue (s)
☐ Changes in Nail Texture ☐ Changes in Skin Color ☐ Hair Growth ☐ Hair Loss ☐ Hives ☐ Itching
☐ Paresthesia (numbness, prickling, or tingling) ☐ Rash ☐ History of Skin Disorders ☐ Skin Lesions/Ulcers
☐ Varicosities

Nervous System: I… ☐ Deny Any Nervous System Issue (s)
☐ Dizziness ☐ Facial Weakness ☐ Headaches ☐ Limb Weakness ☐ Loss of Consciousness
☐ Loss of Memory ☐ Numbness ☐ Seizures ☐ Sleep Disturbance ☐ Slurred Speech
☐ Stress ☐ Strokes ☐ Tremors ☐ Unsteadiness of Gait

Psychologic: I… ☐ Deny Any Psychologic Issue (s)
☐ Anhedonia (inability to experience joy or enjoy life) ☐ Anxiety ☐ Appetite Changes ☐ Behavioral Change(s)
☐ Bipolar Disorder ☐ Confusion ☐ Convulsions ☐ Depression ☐ Insomnia ☐ Memory Loss
☐ Mood Change(s)

Allergy: I… ☐ Deny Any Allergy Issue (s)
☐ Anaphylaxis (history of) ☐ Food Intolerance ☐ Itching ☐ Nasal Congestion ☐ Sneezing

Hematology: I… ☐ Deny Any Hematologic Issue (s)
☐ Anemia ☐ Bleeding ☐ Blood Clotting ☐ Blood Transfusion(s) ☐ Bruises easily ☐ Fatigue ☐ Lymph Node Swelling

PAST HEALTH HISTORY – Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: I… ☐ Deny Any Childhood Illness (es)
☐ ADD ☐ Allergies/Hayfever ☐ Asthma ☐ Atopic Dermatitis (Eczema) ☐ Bedwetting
☐ Cerebral Palsy ☐ Chicken Pox ☐ Depression ☐ Diabetes ☐ Ear Infections
☐ Fetal Drug Exposure ☐ Food Allergies ☐ Headaches ☐ Hepatitis ☐ HIV
☐ Measles ☐ Mumps ☐ Rash ☐ Scoliosis ☐ Seizure Disorder
☐ Sickle Cell Anemia ☐ Spina Bifida ☐ Other (please describe): ____

Adult Illness: I… ☐ Deny Any Adult Illness (es)
☐ Alzheimers ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer
☐ Chicken Pox ☐ Crohn's/Colitis ☐ CRPS (RSD) ☐ CVA (stroke) ☐ Cystic Kidney Disease
☐ Depression ☐ Diabetes (Insulin) ☐ Diabetes (Non insulin) ☐ Ear Infections (frequent) ☐ Emphysema
☐ Eye Problems ☐ Fibromyalgia ☐ Heart Disease ☐ Hepatitis ☐ HIV
☐ Hypertension ☐ Influenzal Pneumonia ☐ Liver Disease ☐ Lung Disease ☐ Lupus Erythema (discoid)
☐ Lupus Erythema (systemic) ☐ Multiple Sclerosis ☐ Parkinson's Disease ☐ Pleurisy ☐ Pneumonia
☐ Psychiatric Problems ☐ Scoliosis ☐ Seizure Disorder ☐ Shingles ☐ STD's (unspecified)
☐ Suicide Attempt(s) ☐ Thyroid Problems ☐ Vertigo
☐ Past history of similar symptoms to your current condition ☐ Other Illness (please be specific): ___________________

Surgeries: I… ☐ Deny Any Surgery (ies)
☐ Angioplasty ☐ Appendectomy ☐ Caesarian Section ☐ Cardiac Catheterization ☐ Carpal Tunnel Repair
☐ Coronary Artery Bypass ☐ Cosmetic ☐ D & C ☐ Dental Surgery ☐ Gallbladder
☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Hysterectomy ☐ Joint Reconstruction ☐ Joint Replacement
☐ Laminectomy ☐ Mastectomy ☐ Pacemaker Insertion ☐ Rotator Cuff ☐ Spinal Fusion
☐ Tonsilectomy ☐ Other (please be specific): ____

Ob/Gyn: I… ☐ Deny Any Ob/Gyn Issue (s)
I… ☐ have never been pregnant ☐ have been pregnant in the past ☐ am currently pregnant
_____ Number of pregnancies _____ Number of complicated pregnancies _____ Number of uncomplicated pregnancies
_____ Number of miscarriages _____ Number of terminated pregnancies _____ Number of Epidural Injections
_____ Number of C-Sections _____ Number of vaginal deliveries

Menstrual History: Age of Onset _________My menses is ☐ Regular ☐ Irregular; I am currently in
☐ Metaphase ☐ Menopause; Date of Last Menses _____/_____/______

Injuries: I… ☐ Deny Any Injury (ies)

☐ Back Injury ☐ Broken Bones ☐ Severe Fall ☐ Fracture ☐ Disability
☐ Head Injury ☐ Industrial Accident ☐ Joint Injury ☐ Severe Laceration ☐ Motor Vehicle Accident
☐ Mild/Moderate Soft Tissue Injury ☐ Severe Soft Tissue Injury

Immunizations: I… ☐ Deny Any Immunization (s)

☐ DTaP(diptheria, tetanus, and pertussis) ☐ Flu ☐ Hepatitis A ☐ Hepatitis ☐ Hepatitis C
☐ Influenza ☐ IPV (Polio) ☐ MMR (measles, mumps, and rubella) ☐ Pneumococcal
☐ PPD (Mantoux Test-TB) ☐ Small Pox ☐ TB ☐ Varivax (chicken pox) ☐ Whooping Cough (Pertussis)

Non-Drug Allergies: I… ☐ Deny Any Non-Drug Allergy (ies)

☐ Animals ☐ Dairy ☐ Eggs ☐ Food Coloring ☐ Mold ☐ Pollen ☐ Wheat
☐ Other (please be specific): ____

Social History

Alcohol: ☐ Never ☐ Social Consumption only
☐ Beer ☐ Liquor ☐ Wine; ______ oz _____ glasses; ☐ Day ☐ Week ☐ Month

Diet (please mark all that apply): ☐ High Fat ☐ High Fiber ☐ High Protein ☐ High Salt
☐ Low Calorie ☐ Low Carb ☐ Low Fiber ☐ Low Salt ☐ Low Sugar

Education (please mark the highest level completed): ☐ Preschool ☐ Elementary ☐ Middle ☐ Junior High
☐ Votech
☐ In High School ☐ Did Not Finish High School ☐ High School Diploma ☐Post High School Classes
☐ Assoc/Technical Degree
☐ In College ☐ College Degree ☐ In Graduate School ☐ Graduate Degree ☐ Doctorate
☐ Other:____________________

Drugs: ☐ Deny any illegal drug use ☐ Deny use of IV drugs ☐ Have not used drugs since_________
☐ Have used drugs for_________

Tobacco: ☐ Deny Tobacco Use ☐ Do not smoke cigars, cigarettes or pipe ☐ Live with a smoker
☐ Quit smoking
☐ Smoke; #________ per ☐ Day ☐ Week ☐ Month ☐ Chew; #______cans per ☐ Day ☐ Week ☐ Year

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Patient's Signature: ____ **Date:** ________________________

QUADRUPLE VISUAL ANALOGUE SCALE

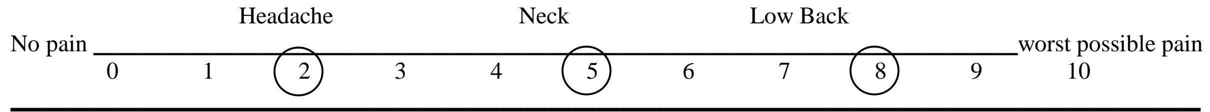
Patient Name:___________________________________ Date:_______________________

Please read carefully:

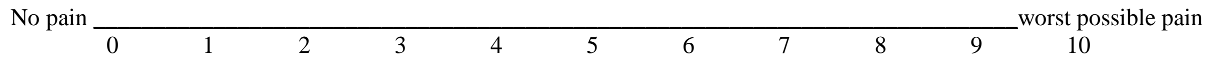
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and the pain at its best and worst.

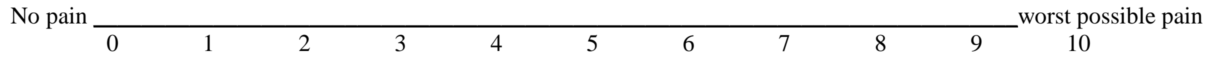
Example:



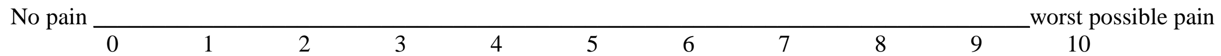
1 – What is your pain RIGHT NOW?



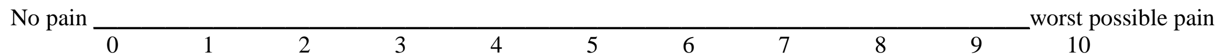
2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



Other Comments:

____
____
____
____

ACTIVITIES OF DAILY LIVING

Patient Name: ______________________________________ Date: _______________ Dr: ____________

Employment:

Occupation: ____________________ Description of Work: ____________________ Work:_____hrs /day or week

Job Classification: ☐ **Sedentary** (<5lbs) ☐ **Light** (5-20lbs) ☐ **Moderate** (20-50lbs) ☐ **Heavy** (>50 lbs)

Lifting Frequency: ☐ **Constant** (67-100%/day) ☐ **Frequent** (33-66%/day) ☐ **Occasional** (0-32%/day)

Lifting Postures: ☐ **from Torso** ☐ **from Knee** ☐ **with Arms** ☐ **High Near** ☐ **Off Posture**

Work Activity Postures: (hrs/day)
☐ **bending: _____h/d** ☐**climbing: _____h/d** ☐ **kneeling: _____h/d** ☐ **pulling: _____h/d** ☐ **pushing: _____h/d**
☐**reaching: _____h/d** ☐ **sitting: _____h/d** ☐**standing: _____h/d** ☐ **twisting: _____h/d** ☐ **walking: _____h/d**

Repetitive Activities: (hrs/day)
☐**computer use/typing:____ h/d** ☐ **phone use: _____h/d** ☐**operation of machinery controls:___ h/d**
☐ **hand tool use: _____ h/d** ☐ **assembly/fine manipulation: _____h/d** ☐ **grasping: _____ h/d**

Condition's Effect On Job Performance:
☐ **Mild** Painful (can do) ☐ **Mod** Painful (limits ability) ☐ **Mod/Sev** (limited duty) ☐ **Sev** (unable to perform) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

__________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
__________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
__________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

Revised 06/2011

LETTER OF NO ACCIDENT OR WORK INJURY

________________________________ ____/____/________
Print Name Date

This is to document that I was not involved in any auto or work related injury for this diagnostic test and / or treatment.

Please note the following:

_____ I state that I was not involved in any auto accident or personal injury caused by any other party. I further state that my diagnostic test and/or treatment is not the result of an injury while on the job or by any other person related to my employment.

Please process my claim with no delay.

Sincerely,

____
Signature

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, ___________________________ and Rhine Chiropractic Center.
Print Name

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read the NPP before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, you cannot be treated at Rhine Chiropractic Center.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling our Privacy Officer at (610) 391-0858.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (in writing), and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

____ _____ / _____ / _________
Signature Date

____ ______________________
Name (please print) If a minor - Relationship

CONTACT INFORMATION

I give permission for you to provide information to me by all of the following where initialed:

_____ **On my home telephone voice mail.** _____ **On my cell phone voice mail.**

_____ **To leave information with:** _______________________________ / ______________
Name **Relationship**

_____ **Via Postal Mail** _____ **E-Mail** ____
E-Mail Address

_____ **No messages left either on an answering machine or with any other individual but myself.**

TREATMENT WAIVER

I understand that my insurance carrier, ____________________,
(Name of Insurance Carrier)
may deem my care to be medically unnecessary, maintenance care or not included in my Chiropractic benefit and will, therefore, deny payment. Rhine Chiropractic Center shall do everything necessary to submit to my insurance carrier.

I further understand that the services rendered by Rhine Chiropractic Center are my financial responsibility and I will be liable for all services rendered.

____________________ ____/____/________
Print Name Date

____
Signature

Definitions of Procedures Performed in Our Office

Adjustment:
This is when Dr. Rhine is specifically adjusting the spinal column, either by hand or by the ProAdjuster.

MFR (Myofascial Release):
Soft tissue application to reduce muscle restriction and tightness. This is done at the time of adjustment by Dr. Rhine while on the ProAdjuster chair. Dr. Rhine will take you through the various ranges of motion and place the ProAdjuster directly on muscle groups. This is a separate and distinct procedure done to facilitate your healing process. The percussion instrument can also be utilized for this procedure.

EMS (Electrical Muscle Stimulation):
This is used to ease muscle spasms, tightness and restriction. The therapist will place round pads on affected areas of pain or spasm.

Decompression Therapy:
Decompression Therapy is a traction-based procedure that can relieve pain associated with disc herniation, degenerative discs, posterior facet and compression-related syndromes. It also enhances the healing process and renders quick, effective pain relief.

Laser Therapy:
Low intensity cold laser beam used to reduce pain, inflammation and swelling to promote healing at a cellular level.

Insurance

Please be aware that your insurance policy may only cover the spinal adjustment and not the therapies. In the beginning of your care, additional therapies are necessary to advance the healing and relief you seek. As a result, an additional cost may be incurred. If you do not want to receive these services, please make that clear to Dr. Rhine.

By signing below, I acknowledge and understand the above statement.

Patient Name ____
Please Print

Signature ____
Signature

Date ____

ASSIGNMENT OF BENEFITS

AUTHORIZATION, ASSIGNMENT, ACKNOWLEDGMENT AND UNDERSTANDING

AUTHORIZATION TO RELEASE INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you (Larry K. Rhine, D.C. and whomever he may designate as his associates and assistants) and hereby release you of any consequence thereof.

ASSIGNMENT OF PAYMENT: My attorney and/or insurance company are hereby requested to pay directly to Larry K. Rhine, D.C., and monies due him on account, the same to be deducted from any settlement made on my behalf. Further, it is understood that I, the undersigned, agree to pay the full amount of the charges, should my condition be such that it is not covered by my policy or if for any reason the insurance company and/or attorney refuses to pay my claim.

MEDICARE ASSIGNMENT: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

CONSENT TO CARE FOR A MINOR: I hereby authorized Rhine Chiropractic Center to administer care as deemed necessary to: ____
Print Minor's Name

I hereby acknowledge that I am receiving (or about to receive) health care services at Rhine Chiropractic Center and that I have been advised that Rhine Chiropractic Center is willing to wait for payment for these services provided that there continues to be a reasonable chance that payment will be made either by the insurance proceeds or out of the settlement of a liability case.

I understand that if it is determined either:

a) That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to Larry K. Rhine, D.C. or to make other provisions for the protection of the interest of Larry K. Rhine, D.C. , or
b) If a liability claim exists and attorney refuses to agree to protect the interest of Larry K. Rhine, D.C., or
c) If I have not engaged the services of an attorney,

then payment of services at Rhine Chiropractic Center will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first.

______________________________   ____/____/________
Print Name   Date

____
Signature

Patient Authorization Regarding Chiropractic Care being provided in an "Open Adjusting" Environment.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Rhine Chiropractic Center or on your relationship with our staff.

Your signature indicates your authorization for open adjusting. If signing for a minor, please state your relationship to the patient (parent or guardian).

PATIENT NAME ____ **DATE:** ___/___/______
(PLEASE PRINT)

PATIENT SIGNATURE____

IF A MINOR, PARENT / GUARDIAN SIGNATURE
____

RELATIONSHIP TO PATIENT ____

This authorization is effective as of the date of signing above and will be valid for a period of 24 months. You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

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